2025 Season Program/Session: _______________

American Youth Foundation
Miniwanca | 231-861-2262 (phone) • 231-861-5244 (fax)
Merrowvista | 603-539-6607 (phone) • 603-539-7504 (fax)
www.ayf.com

AYF Camper Physical Exam Form

This must be completed and signed by the participant's primary licensed healthcare provider. This form verifies the date of child's last physical (*must be within 24 months of camp start date*) and healthcare provider recommendations for participation in the camp program.

***TO EXAMINING LICENSED PROVIDER**: AYF camp programs are physically and mentally strenuous at times. An individual with normal mental and physical capacity can usually expect to do well in our programs. Examples of activities in our programs include, but are not limited to, swimming, backpacking, sailing, remote camping, traversing varied terrain, exposure to the natural elements and using challenge courses of 50' high or greater. The camper must be able to safely get from one place in camp to another without being with or requiring another camper/staff. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitations for this participant in our program.*

Name of Participant: ___________________________ **Date of Birth:** ____________ **Date of Exam:** __________________

Health History (please check all that apply)

Allergies: ☐ None ☐ Drug ☐ Food ☐ Stinging Insect ☐ Other **Epi-Pen Required?** ☐ Yes ☐ No

Specify Allergen & Describe Reaction: ____

Asthma: ☐ Yes ☐ No Type: ______________________ Well Controlled? ________________ **Inhaler?** ☐ Yes ☐ No

For participants prescribed epi-pens or inhalers: Please complete and sign the attached **Emergency Medication Permission Form** (page 2)

Significant recent illness, injuries/fractures, concussions, seizures, headaches, bowel or bladder issues): ______________________________

____

Chronic Medical Conditions**:** ____

Does the participant have any Developmental/Social/Emotional History (examples: anxiety, depression, suicidal ideation, ADHD, ASD, bedwetting, IEP or 504)?: ☐ No ☐ Yes If yes, please describe:____

Does the participant have a Vision or Hearing Impairment? ☐ No ☐ Yes If yes, please describe: ___________________________________

List Hospitalizations and/or Surgeries:____

Restrictions: Are there any active concerns or restrictions which would preclude this child from participating fully in a recreational program at camp? (diet, medical, swimming, physical, psychological): ☐ None ☐ Yes (please explain): ______________________________________

____

Medications*

List ALL medications (including over-the-counter, sleep aids/vitamins/supplements, prescription, etc.) the camper will be taking at camp.

*Please note: Routine medication times at camp are after meals and at bedtime. If camper requires a dose of medication outside of these timeframes, parent/guardian must contact camp to ask about accommodations.

Medication Name	Dose (mg)	Frequency/Time(s)	Reason

Immunizations

Date of last Tetanus Immunization: _____________ Please attach an up-to-date immunization record.

TB Risk Assessment: Low Risk ___ High Risk ___

(Test not necessary if deemed low risk) Test Results: _______________ Date of Test: ___________________________

The above-named person has been determined to be physically and emotionally fit to participate in camp and camp activities without restrictions except as noted above.

Licensed Provider Signature (Required) _______________________________ Date:__________________________

Licensed Provider Name (printed):____________________________________ How long have you known camper?_____________________

Office Address:____ Telephone: (____)________________

If have any questions, please contact AYF Lead Health Officer, Carrie Smith, at 603-581-8611. Once completed, ***please return form to guardian to upload to the camper's online AYF CampBrain portal.***

2025 Season Program/Session: _______________

American Youth Foundation
Miniwanca | 231-861-2262 (phone) • 231-861-5244 (fax)
Merrowvista | 603-539-6607 (phone) • 603-539-7504 (fax)
www.ayf.com

AYF – Permission to Possess and Use Emergency Medications

Must be signed by a Licensed Healthcare Provider and Guardian

Licensed Healthcare Provider: Please complete this form if the participant is prescribed a rescue inhaler, EpiPen, or other emergency medication that they will be bringing to camp. In addition to this form, the participant must provide an extra medication dose/device to be kept at the Health Center for back up and/or emergencies.

Name of Participant: ___________________________ **Date of Birth:** ________________

Diagnosis requiring Emergency Medication: ____

Other Medical Conditions: ____

Medication Order

Medication Name:__________________________________ Date of Medication Order: ____________________
Route and Dose: ____________________________________
Frequency/Time: ____________________________________

1. Does the participant need assistance with administration? ☐ No ☐ Yes If yes, please describe:

2. Specific recommendations for administration (list symptoms that would indicate need for medication):

3. List side effects, contraindications and or adverse reactions to be observed if the medication is administered:

4. Provide recommendations for care after medication is administered (ie: Health Team observation? How long? Return to activity after ______ amount of time):

5. Action plan is attached: ☐ Yes ☐ No

As this participant's provider, I give permission for this participant to possess and use the above medication. This participant has the knowledge and skills to safely possess and use the medication in a camp setting during AYF Camps and NLC programs.

Licensed Provider Signature (Required) _______________________________ Date:_________________________________
Licensed Provider Name (printed):____________________________________
Office Address:____ Telephone: (____)______________________

Parent/Guardian Section

I will provide a second dose of this medication to be kept at the Health Center for emergencies.

As the legal guardian of the above listed child, I grant permission to the American Youth Foundation to allow my child to have readily available (carry or possess outside of the regular supervision of the healthcare staff) and self-administer, as medically necessary, the medications listed below.

Parent/Guardian Signature: ___________________________________ Date: ____________________________________

Print Name: ____ Relationship to participant: __________________

If have any questions, please contact AYF Lead Health Officer, Carrie Smith, at 603-581-8611. Once completed, ***please return form to guardian to upload to the camper's online AYF CampBrain portal.***